

CHAPTER 75
STATEWIDE OBSTETRICAL AND
NEWBORN INDIGENT PATIENT CARE PROGRAM

641—75.1(255A) Definitions.

“Applicant” means a person for whom assistance under this program is being requested.

“Delivery” means that the delivery occurs after 20 weeks gestation.

“Director” means the administrator of a maternal health center or other designated agency.

“Family” means a group of two or more persons related by birth, marriage, or adoption who reside together or a unit of one who is an unrelated individual not living with any relatives. The unborn fetus will be counted as a family member.

“Nonquota case” means a patient who is provided obstetrical or newborn care services at the University of Iowa Hospitals and Clinics under the indigent nonquota obstetrical care program established pursuant to Iowa Code chapter 255 and referenced in Iowa Code section 255A.2.

“Obstetrical and newborn care services” means those types of services as recognized by the latest editions of The American College of Obstetricians and Gynecologists, “Standards for Obstetric-Gynecologic Services” and The American Academy of Pediatrics, “Standards and Recommendations for Hospital Care of Newborn Infants.”

“Poverty level” means poverty income guidelines established by the United States Department of Health and Human Services.

“Program” means the obstetrical and newborn indigent patient care program for quota cases.

“Provider” means a licensed hospital or a licensed physician who agrees to service eligible patients.

“Quota case” means a patient who is provided obstetrical or newborn care by a licensed hospital or physician under the obstetrical indigent patient quota program established pursuant to Iowa Code section 255A.4.

“Resident” means the individual is a legal resident of the state and resides in one of the designated 90 counties.

“Spendedown” means the process by which an applicant obligates income for allowable medical expenses to reduce income to a qualifying level. The medical expenses used for spenddown cannot be paid for with funds from this program.

“Spendedown interval” means one month for delivery services and six months for antepartum and delivery services.

641—75.2(255A) Covered services. The following obstetrical and newborn care services may be provided through the obstetrical indigent patient care program:

1. Antepartum and postpartum care except where patient qualifies for antepartum and postpartum care provided by the department of public health, maternal and child health care program.
2. Normal delivery.
3. Cesarean section.
4. Newborn hospital care.
5. Sick newborns who qualify as a quota case will be covered until the patient is stabilized and transferred to University of Iowa Hospitals and Clinics, where the patient may be eligible to receive care as a county quota indigent patient pursuant to Iowa Code chapter 255.
6. Inpatient transportation from one hospital to another when authorized by a medical provider.
7. One outpatient visit for false labor.
8. Excluded services for quota cases will include but not be limited to elective abortion, elective hysterectomy, circumcision, nonobstetric related procedures and services.

641—75.3(255A) Quota assignment. The department of public health shall establish the quota annually for each county. The formula used shall be based upon, but not limited to, the following criteria:

1. Dollars available to the program.
2. Average number of births for the most recent three-year period for each county.
3. Per capita income for each county.

641—75.4(255A) Eligibility criteria. The certification process to determine eligibility for services under this program will include the following requirements:

75.4(1) Income.

a. Income guidelines will be set at 185 percent of the poverty income guidelines published by the United States Department of Health and Human Services. State income guidelines will be adjusted following any change in Department of Health and Human Services guidelines.

b. Income information will be provided by the applicant, who will attest in writing to the accuracy of the information contained on the application. The director may request verification of income.

c. All earned and unearned income of family members as defined by DHHS poverty guidelines will be used in calculating the applicant's gross income for purposes of determining initial and continued eligibility.

d. Income will be estimated prospectively as follows:

(1) Annual income will be estimated based on the applicant's income for the past three months unless the applicant's income will be changing or has changed, or

(2) In the case of self-employed families the past year's income tax return will be used in estimating annual income unless a substantial change has occurred.

(3) Terminated income will not be considered.

e. An applicant for obstetric services under this program whose income falls between 185 percent and 300 percent of the poverty level guidelines may qualify through spenddown of medical expenses of all family members as follows:

(1) The applicant must provide copies of medical bills or a statement from the providers of projected medical expenses.

(2) Medical expenses which can be used to meet spenddown are as follows:

1. Health insurance premiums, deductibles, or coinsurance charges.

2. Medical and dental expenses as defined by the Internal Revenue Service.

(3) In order to qualify with spenddown, the amount of spenddown, adjusted by one-twelfth, must be equal to or less than the projected and actual medical expenses.

75.4(2) Resources.

a. The resource limitation for an applicant will be \$10,000 per household.

b. The following are countable resources:

(1) Unobligated cash.

(2) Savings accounts.

(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

c. Resource information will be provided by the applicant, who will attest in writing to the accuracy of the information contained on the application. The director may request verification of resources.

75.4(3) Noneligibility for Title XIX or medically needy without spenddown. In order to be eligible, the applicant must not be eligible for services under Title XIX or the medically needy program without a spenddown.

75.4(4) Residency. The applicant for this program must be a legal resident of Iowa currently living in any county except Clinton, Cedar, Scott, Muscatine, Louisa, Washington, Iowa, Johnson, or Keokuk.

641—75.5(255A) Application procedures.

75.5(1) A person desiring obstetrical and newborn care under this program, or the parent or guardian of a minor desiring such care, may apply to the director of the maternal health center serving the person's county of residence at any time between confirmation of the pregnancy and not later than 60 days after delivery. If there is no maternal health center covering that county, the department will designate an agency.

75.5(2) The applicant will provide the following information to be considered for eligibility under this program:

a. Income and resource information on an application form.

b. Written verification obtained from the department of human services certifying that the applicant is not eligible for Title XIX or the medically needy program without a spenddown. The applicant will submit this copy within 60 days of applying with the director. To meet this 60-day deadline, the applicant will need to apply with the department of human services before or immediately after contacting the director.

75.5(3) Assignment of quotas shall be on a first-come, first-served basis based upon application date.

75.5(4) The director will provide written notification to the applicant regarding determination of eligibility or noneligibility and applicant's right to appeal a denial.

75.5(5) After an applicant has been determined to be eligible, the patient or provider will report any changes in eligibility or status of pregnancy to the director within 10 days from the date the change occurred.

75.5(6) Standardized application, determination of eligibility, and certification forms will be furnished by the department of public health to the directors.

75.5(7) Copies of appropriate certification forms will be mailed by the director to the department of public health as follows:

a. In counties covered by the department of public health's maternal and child health program, certification forms will be sent at 26 weeks or more gestation.

b. In counties not covered by maternal and child health programs, certification forms will be sent upon determination of eligibility for patients whose antepartum care will also be paid through the program.

75.5(8) Receipt of a certification form for a quota patient by the department of public health shall be considered the point in time when the quota has been used.

75.5(9) A woman who resides in a county which exceeds the patient quota allocated for the county, and who meets eligibility under rule 75.4(255A) shall be served at the University of Iowa Hospitals and Clinics pursuant to Iowa Code section 255.16. A woman who resides in a county with available quota and who meets eligibility under rule 75.4(255A) may be served at the University of Iowa Hospitals and Clinics pursuant to Iowa Code section 255.16.

75.5(10) Maternal health center directors shall negotiate 28E agreements with general relief directors for the purpose of coordinating application and eligibility services for obstetric patients under Iowa Code chapter 255.

641—75.6(255A) Reimbursement of providers.

75.6(1) The University of Iowa Hospitals and Clinics and other hospitals will submit their billings on the UB 82, uniform hospital billing form, and physicians will submit their billings on the Health Care Financing Administration form HCFA 1500. Forms will be furnished by the providers.

75.6(2) Providers will submit bills after delivery but not more than 60 days after the delivery or after determination of eligibility, whichever occurs later, to the department of public health.

75.6(3) Reimbursement for physicians and hospitals will be based upon the Title XIX rates. Bills will be adjusted accordingly by the department of public health and forwarded to the department of revenue and finance for payment.

75.6(4) Providers may be reimbursed for antepartum care prior to the patient becoming ineligible, as long as the patient is counted as a quota case.

75.6(5) On an annual basis the department of public health will furnish participating physicians with a list of reimbursable procedure codes and maximum rate.

75.6(6) The obstetrical indigent care fund is last pay. Private insurance shall be billed first.

75.6(7) All providers of services to quota obstetrical and newborn patients shall agree to accept as full payment the reimbursements allowable under the medical assistance program established pursuant to Iowa Code chapter 249A, up to a maximum of medical assistance's average reimbursement for the most recent fiscal year. When the medical assistance reimbursement methodologies change, the maximum reimbursement may be based upon projection.

75.6(8) The obstetrical and newborn indigent program will pay, out of a set-aside fund, for certain cases that exceed the current year's maximum reimbursement rate. Cases that can be paid out of this fund are:

a. Allowable physician and hospital costs associated with DRGs 370, 371, 372, 374, 375 for the woman. Costs associated with DRGs 383, 384 will be covered if followed by a qualifying delivery event.

b. Allowable physician and hospital costs for the newborn associated with DRGs 385, 385.1, 389, 390.

c. Care provided to newborns under DRGs 386, 386.1, 387, 387.1, 388, 388.1, 389.1, 390.1 are defined under rule 75.2(255A) as being outside the scope of this program. These services could, however, be covered by Iowa Code chapter 255 or medically needy programs.

d. Physicians who provide obstetrical or newborn care at the University of Iowa Hospitals and Clinics are not entitled to receive any compensation for the provision of such care to persons certified as eligible under this program.

75.6(9) In all other cases, the maximum reimbursement level will apply. If the total reimbursable charges exceed the maximum reimbursement level, reimbursement to providers will be prorated based upon allowable reimbursement amounts.

75.6(10) Certifications for quota cases received by June 30 will have medical assistance's average reimbursement and the 10 percent fund encumbered.

641—75.7(255A) Reassignment of county quotas.

75.7(1) Unused quota numbers will be assigned by the department of public health after March 31 of each year to counties according to receipt of request on a case-by-case, first-come basis.

75.7(2) Request for additional quotas cannot be made until all quotas have been used in a given county.

75.7(3) Requests for additional quotas may be submitted by directors and must be based on pending applications. Requests will be made on forms provided by the department of public health designed to provide necessary information regarding pending applications.

641—75.8(255A) Appeals and fair hearings.

75.8(1) *Right of appeal.* An applicant shall have the right to appeal whenever a decision of the director or the state program results in the individual's denial of eligibility for the program or denial as a quota case. No appeal can be filed for denial as a quota case, if there are no quotas available. Quotas would not be available if already assigned or sequestered to cases under appeal. Quotas will only be held when applicant is appealing a change in status.

75.8(2) Request for reconsideration. The applicant seeking to appeal shall first request reconsideration by the director of the denial of eligibility for this program or denial as a quota case. The written request shall be made within 15 days from the date the individual received notice of the decision which is the subject of appeal. The written request shall state the adverse decision being appealed and the reasons the applicant believes state standards were not correctly applied. The director shall reconsider the application and make a written determination with notice of right to appeal to the state within 10 days of receipt of the request. If the denial stands, the applicant may appeal to the department of public health.

75.8(3) Request for hearing. An appeal is brought by filing an appeal with the Division Director, Division of Family and Community Health, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075, within 30 days of the director's final determination in subrule 75.8(2).

75.8(4) Contested use. Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

75.8(5) Hearing. The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

75.8(6) Decision. A written decision of the hearing officer shall be issued, where possible, within 30 days from the date of the request for a hearing unless the parties agree to a longer period of time. The decision of the hearing shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings 10 days after it is received by the aggrieved party unless an appeal to the director of public health is taken as provided in subrule 75.8(7).

75.8(7) Appeal to director. Any appeal to the director of public health for review of the proposed decision and order of the hearing officer shall be filed in writing and mailed to the director of public health by certified mail, return receipt requested, or delivered by personal service within 10 days after the receipt of the hearing officer's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the hearing officer. Any appeal shall state the reason for appeal.

75.8(8) Record of hearing. Upon receipt of an appeal request, the hearing officer shall prepare the record of the hearing for submission to the director of public health. The record shall include the following:

- a. All pleadings, motions and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections and rulings thereon.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the hearing officer.

75.8(9) Decision of director. The decision and order of the director of public health becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

75.8(10) Exhausting administrative remedies. It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director of public health or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

75.8(11) *Petition for judicial review.* Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Division Director, Division of Family and Community Health, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

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